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AUTHOR Pittman, Mildred M.
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ABSTRACT

The multidiscipline credentialed health care worker is an alternative to the current status of health care workers and worksites. Practitioners and educators in health care delivery are unable to reach a consensus as to the number of disciplines. Existing educational programs offer a wide range of programs enabling persons to attain health professional status and/or pursue credentials. A nationwide effort to gain licensure by numerous allied health disciplines has encouraged discipline-specific efforts to substantiate the need for licensure. The demand for accountability has led to the need to display cost efficiency while maintaining quality health care. Credentialed in at least two disciplines, the multidiscipline credentialed health care worker should be able to provide competent services in a more cost-effective manner than two single-discipline prepared persons. Some dimensions of the current situation are supportive of the concept--considerations of the individual, and the educational processes including the educator, the disciplines, and the employers. Unresolved dimensions are realistic discipline combinations and the level of preparation at which it is realistic to pursue dual credentialling. Multidisciplinary and interdisciplinary education are different, but some of the needs of the interdiscipline approach could be met by the multidiscipline design. (YLB)

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The Multi-Disciplined Health Worker in Vocational Education

By Mildred M. Pittman, Ed.D.
Coordinator
Graduate Programs
Indiana University at Indianapolis
School of Education

Presented

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Accountability and multidiscipline credentialed workers; a purposeful combination.

by

Mildred M. Pittman

Introduction

Accountability has become a daily message to all health care providers across the vast range of institutions included in the health care delivery system. Although hospitals have gained predominance among the institutions affected by changes in third party payment, other institutions have realized the need for accountability either by direct or indirect effect. The demand for accountability has occurred simultaneously with numerous discipline efforts in many states to establish licensure. Fundamentally licensure is supported as a means of protecting patients/clients from mistreatment by unprepared, unqualified health care workers. Licensure is promoted as a means of assuring the continuance of quality health care; whereas accountability demands that health care be provided in a cost effective manner. The realization of both efforts will require

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scientific investigation and innovative education designs. Both endeavors will be more difficult to achieve due the complex environment of delivery system. A delivery system that has always been considered complex by the general public,is now even more confusing due to massive changes in "third party" payment.

Although many alternatives to the current status of health care workers and work sites have been presented, many more are both reasonable and necessary to maintain the level of health care the American populace has grown accustomed to as a Right. An alternative to be pursued in this presentation is the multidisciplined credentialed health care worker.
This health care provider can be defined as a worker in health care delivery who is qualified to render services,i.e.tasks, typical of more than one discipline. In this context, the term multidiscipline should be not interpreted as services common to more than one discipline.

Disciplines in HOE

Researchers are not in agreement as to the number of disciplines;moreover, consensus has not been reached among practitioners and educators in health care delivery.
One HEW listing groups Occupational titles in Allied Health and Nursing fields into fourteen health fields. Illustrative of "field" in this categorization is "Therapy" which includes fifteen occupational titles including "Occupational Therapist". While programs of study are occupational title specific, the

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discipline connotation implied by this author is exemplified by the grouping of Medical Laboratory Technician (MLT)and Medical Technician(MT) as a discipline, whereas the HEW listing includes both MLT And MT and others in the field of Medical Technology.

Existing educational programs

Programs preparing health care workers eligible for credentialing include all levels of post secondary instruction. A comprehensive categorization of these educational designs includes;

Certificate

Associate degree

Baccalaureate degree

Master's degree

Doctorate degree.

Post Doctorate studies

The certificate is most frequently awarded for completion of a program extending one year or less. Two years is the standard length of enrollment for the associate degree and four years is conventional for the baccalaureate. Graduate (post baccalaureate) studies' requirements are traditionally listed as academic credit hour requirements, 30-36 hours for the master's and 90-110 for the doctorate. Finally, the number of credit hours in a post doctorate program remains the perogative of the institution. With the exception of Nursing,few health care disciplines, have created and maintained multiple levels of educational

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preparation. The most frequently occurring pattern in nursing education is the preparation of generalist in the certificate, associate and baccalaureate programs; the preparation of a specialist in the masters program and preparation of a generalist at the doctorate level,with the preparation of specialist beyond that. The above consideration of nursing is merely illustrative, not a precise presentation of the vast array of curricular designs and institutional preferences. Currently the Committee of Allied Health Education and Accreditation (CAHEA) reports that 3,062 Accredited programs ,awarding certificate,and associate, baccalaureate degrees are available across the United States. The CAHEA list is inclusive of Allied Health education programs;the exclusions are more readily identified by the definition provided by the Health Professions Training Act (HPTA),S 2559.

> That bill defines allied health professional to mean an individual who: (1) has received a certificate or an associate, bachelor's, master's, or doctoral degree or post baccalaureate training in a science relating to health care; (2) has responsibility for the delivery of health care services or related services including services relating to the identification, evaluation, and prevention of diseases and disorders; dietary and nutrition services; health promotion services; rehabilitation services; or health systems management services; and (3) is not a graduate of a school of

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> medicine, osteopathy, dentistry,veterinary medicine, optometry, podiatry, pharmacy, public health, or chiropratic or of a graduate program in health administration or clinical psychology.(6)

In summary, the existing educational programs offer a wide range of programs which enable persons to attain allied health professional status and/or pursue credentials. For these purposes, the standard dictionary provides a guide. "Credential" is defined as "a letter or certificate given to a person to show he has a right to confidence or to the exercise of a certain position or authority."

Licensure as a goal of allied health disciplines.

The drive for licensure(a form of credential) by numerous Allied Health disciplines is nationwide, ranging from states where only a few allied health disciplines are licensed to states where many disciplines are licensed. As expected, this nationwide effort to gain licensure has encouraged discipline specific efforts to substantiate the need for licensure. The major supports for licensure are included in the Occupational Therapy Newspaper(1984) explanation of state licensure laws.

> A state licensure law establishes legal definition of a profession within a state, establishes educational experience and exam requirements, and provides a means to prevent unqualified people from practicing a profession. This means protects the consumer of

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> services from unskilled or improperly trained individuals. A licensure law also establishes uniform statewide standards which must be utilized by public and private agencies such as hospitals, institutions and school systems in employing people in a given profession. (1)

In addition to the general statements relating to licensure, the Occupational Therapy Association (1984) has published the following warning:

> The author reminds professionals that first and foremost, a licensure law protects the consumer of services from unskilled or improperly trained practitioners by assuring minimum standards of competence. The law protects individuals from interference in professional activities by persons who are not qualified. This law also establishes statewide credentialing for professionals.(1)

Also as expected, opponents to licensure, principally employers, have responded with reasons that licensure should not be permitted. In Indiana, legislative committee public meetings have provoked the major reasons for not supporting licensure and include:

> From a state hospital association:licensure limits the number of people who are eligible to practice certain skills, thus affecting supply and distribution of

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health care personnel, qualified personnel tend to be available in urban areas, creating shortage of professionals in rural area; health care costs increase because fewer qualified personnel can command high wages; licensure narrows scope of practice; no research indicates that licensure promotes competency, protects the public or insures quality of care and licensed facilities are legally responsible for personnel they employ.

From a state medical association: support of a moratorium on licensure and a suggestion that the following topics receive consideration- whether an unlicensed professional threatens a consumer's life, health, economics or wellbeing; whether the lay-person can evaluate the qualifications of a health professional and whether licensure benefits truly out-weigh potential harm.

From an advisory committee: licensure of additional allied health occupations personnel is unnecessaary, and that requirement of such would only increase health care costs without improving quality of care.

From another source: licensure of allied health professionals who are graduates of CAHEA accredited programs is unnecessary; scope of practice provisions in licensing statutes unnecessarily limit available personnel resources and statutes are out to award use

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of professional title rather than limit performance of procedures.

Accountability:the current theme

The rush to accountability in health care delivery has been created primarily by the initiation of new payment schedules which are prospective and based upon Diagnosis Related Groups(DRG)s. An issue which has commanded monumental attention in the literature. The immediate outcome is the need to display cost efficiency while maintaining quality health care. The relative cost of utilizing credentialed workers throughout an institution has been investigated with varying results. The assurances of no cost increase by using credentialed health care personnel are given by disciplines seeking licensure. The respiratory therapy association claims "studies have not shown an increase in salary of those persons in newly regulated professions". Which are the most convincing evidences remains unanswered and the evolving health care situtation increases the difficulty of conducting more conclusive research.

A dimension of accountability, specifically in the hospital milieu, is evidenced in the changes in programs reported by CAHEA. In their 1985 Special Fact Sheet, they report a 5 year (1980-1984) decrease of 262 (10.2%) in programs sponsored by Hospitals, Clinics and Blood Banks. Hospital sponsored programs have typically included considerable amounts of clinical education. It is not surprising that included among the programs discontinued most frequently are Medical Technologist,

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Radiographer and Cytotechnologist.

Needed: an alternative

An alternative which is worthy of investigation is the multidiscipline credentialed health care worker. Credentialed in at least two disciplines, this worker should be able to provide competent disciplined services in a more cost effective manner than two single discipline prepared persons. Not all health care personnel would or should be expected to acquire dual credentials ;however, there are numerous employment sites,i.e., small rural hospitals, that should welcome this type of worker.

The concept of multidiscipline health care workers is not new, however, the current situation commands consideration of this concept from several points of view. Most commanding are the considerations of the individual, the educational processes including the educators, the disciplines and the employers. Obviously success of the multidisciplined Health Care worker would depend upon the acceptance and support of this concept by all the parties listed.Not surprising is the fact that some dimensions of the current practices are supportive of the concept while others are not.

The individual multidisciplined worker could come from either the ranks of health care workers or could be in the group of interested persons seeking preparation for entry into the health care professions. Of greatest interest to the potential student would be the employability of this type of worker. Concurrently

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the projected need for this type of health care delivery worker would require different information gathering techniques than those commonly employed to determine manpower needs. Local data would need to be collected. Community bared surveys would be one means to determine the probable employability of the dual credentialed worker. The individual contemplating multidiscipline preparation would be interested in the compensation such a worker would be entitled to. Ideally, employment as a multidisciplined health care worker should warrant more payment than a single discipline worker. More fundamental to the individual student concerns are the qualities and quantity of the educational program preparing the multidisciplined worker. The individual student will become increasingly disenchanted with a program that extends to twice the average length of time required for one discipline preparation.

Educators would hold a key position in the establishment and continuance of a program designed to prepare a multidisciplined person. Accountability is a theme in educational institutions as well as in health care settings. An educational program designed to prepare individuals for multi-discipline credentials should enjoy increased enrollments if -the manpower need for the worker is projected, if-innovative curricular designs are utilized and if-the programs acquire the necessary accreditation/approval. Profound educational articulation is necessary to assure appeal to students. Program approval/accreditation is essential to

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assure completers eligibility for credentialing.
The health care disciplines would be required to reconsider existing restrictive requirements based upon exclusiveness in preparation. Delineation of role, reflective of preparation and based upon competency ,would assist in the efforts toward both licensure and innovative preparation. Activities of turf guarding are inappropriate in a nationwide emphasis on accountability in health care delivery. Disciplines should be able to identify the role of their practitioners and confirm that the competencies are related to credentialing statuses. Such role delineation cannot be successful if determined in isolation and then forced upon the employer, educators and other disciplines. Employers and educators both would welcome the precise delineation of the "entry into practice" level of competency for the disciplines but only if the role determination is done in concert with all other parties involved.

Employers faced with the immediate and long range emphasis on cost effectiveness, while legally and ethically obligated to employ credentialed personnel, should welcome the multidisciplined health care worker. While not the solution to all components of cost effectiveness, the multidisciplined credentialed health care worker would contribute. Health care is a labor intensive service industry and any decrease in salaries has the immediate effect of cutting costs.

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Unresolved dimensions

While the above arguments for the multidisciplined credentialed health worker are hopefully convincing, some dimensions of this concept are less obvious. One of two unresolved dimensions is "Which discipline combinations are realistic?". Dual credentialing is the beginning goal but which combinations are practical? Are combinations of disciplines more dependent upon the employment site than the disciplines? A second unanswered question is"At what level of preparation is dual credentialing realistic to pursue?". The answer to the 2nd question appears more easily derived than an answer to the first. The cost of preparation (years of enrollment), employment rewards (salary) and existing minimum credentialing requirements all need to be considered. Suggested program levels revolve around the associate degree, promoting the possibility of 2 associate degrees or an associate degree and a certificate. A certificate award could be based upon additional studies, either before or after the associate degree award.

Answers to the first question, i.e., "which combination or combinations?" are more difficult to provide. The employment site may be the determining factor. Understandably large teaching institutions (500+ bed hospitals) may have little use or need for dual credentialed persons. As employers they may need singly credentialed persons to staff discipline specific departments. But what about the smaller hospital, specifically the community hospital, with less than 100 beds which provides the wide range

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of health care a community requires?

A contemporary program

One "success" story, including the preparation of multidiscipline health care workers is told by the personnel of Southern Illinois University at Carbondale, School of Technical Careers. Project Director, Archie G. Lugenbeel declares

> Rural Allied Health Manpower Project (RAHMP) worked. Of the 30 trainees, 28 are working in full-time hospital positions in the specialty areas for which they trained. --About 84 percent of all students enrolled, completed two clinical skills which offered the health facilities a service potential and personnel flexibility not available to them before the program.--Some of the multiskilled graduates are serving in interdepartmental positions, others "fill-in" for vacation, sickness, absence and emergency coverage.(43)

Community hospitals in rural areas need personnel credentialed in Respiratory Therapy, Physical Therapy, Occupational Therapy, Medical Technology, Radiology Technology, among others as minimum staff. The professional level of preparation is the usual requirement; however, they also need individuals prepared at the technical level. Dually credentialed persons prepared at the technical level appear a realistic choice to provide both alternative and complementary services as described in the RAHMP. Prepared and credentialed, these persons are in a class above and

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beyond any person prepared in an OJT fashion.

Unanswered is the preferred combination of disciplines, some appear akin by virtue of their role, i.e., physical and occupational therapy yet with the role delineation necessary for licensure, the definitive role of each discipline of therapy becomes more exclusive. Lugenbeel (1981) lists "successful" combinations

> Dual skills are represented in the following areas: five in x-ray/medical laboratory, two in x-ray/respiratory therapy; one in medical laboratory/respiratory therapy and one in respiratory therapy/renal dialysis.(43)

Another meaningful combination is listed as available to selected students. Housed in the School of Allied Health Professions, State University of New York at Stony Brook, it is known as the Cardiorespiratory Sciences Program. This baccalaureate degree awarding program "has received dual professional accreditation, graduates are eligible to take registry examinations in Cardiopulmonary Technology (given by the National Society for Cardiopulmonary Technology) and in Respiratory Therapy (given by the National Board for Respiratory Therapy)." The program brochure states "Students who complete this baccalaureate program in Cardiorespiratory Sciences may look forward to careers as supervisors, technical directors, educational directors, research participants and clinical specialists in the fields of

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Respiratory Therapy or Cardiopulmonary Technolcgy." (Brochure)

Follow-up (placement) figures of graduates from this program are not currently available.

"Imaging" is emerging as a more appropriate discipline label than the existing Radiology or previous X-Ray nomenclature. Concomittment to such developments is the emergence of the subspecialities of Radiation Therapy, Sonography, Nuclear Magnetic Resonance and Ultrasound which are seeking credentialing. Conceivably, when available at the technician level of preparation, dual credentialing should/would include two areas in this category.

The medical laboratories are requiring specialists and subspecialist, some of which warrant separate credentialing. No doubt, the MLT could enhance their fundamental skills and gain credentialing in a related role.

The possibilities of combinations of nurse and other credentialing do not appear as probable as combinations within Allied Health. However,Nursing is currently professing a nation wide thrust toward the Baccalaureate in Nursing as entry into practice. When legislated in every state the requirements would mark the end of the Associate Degree in Nursing and Diploma preparation as "Entry into Practice". These two modes of preparation (technical level)would serve the criteria previously identified in this presentation. Nurses have rarely pursued allied health occupations and foresaken the nurse credential in lieu of a newly acquired allied health credential. However, in

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the future, already prepared technical and vocational level nurses may become very interested in such dual preparation. The generalist preparation of both the vocational and technical nurse may provide an optimum base for the development of dual competencies.

Conclusion

While the dual credentialing with the concurrent privileges of practicing both disciplines may seem unprecedented in the Allied Health/Nursing configurations, there are many dually credentialed persons in the schema of health care delivery system. Researchers frequently hold both MD and PhD degrees. Educational consultants and others more directly involved in "legal practices" may hold both the RN credential and the JD degree or the MD and JD degrees. Admittedly in those instances there may not be the precise need to practice an area of study in isolation from the other due to the intermingling and overlapping. The practice of one of two HO disciplines in which the persons has credentials will more easily be achieved if there is more accurate role delineation. Frequently both tasks and equipment are discipline specific while the arena may at times be identical.

The technical level prepared, credentialed person shall continue to be in demand in the health care labor market. The dual credentialed worker should also expect continued demand. The employment demand would rely upon the adequacy of preparation for both roles (the educator's responsibility), the acceptance of one

individual with two credentials (the disciplines responsibility); and reward for dual credentialing (the employer's responsibility). Society's acceptance of the dual credentialed health care person would be influenced by the forces listed above. However, it is also reasonable to assume society's acceptance if the the practice is proven cost efficient while providing competent health care. Individual interest in the pursuit of such preparation would undoubtedly be moderate and beyond. However, how far beyond will depend on all parties involved.. Predictably, the frequent use of dual credentialed health care workers will provide some relief to the dilemma of the need for credentialed health care workers in a cost effective manner.

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Interdisciplinary vs multidisciplinary Allied Health Education

The multidisciplinary configuration with dual credentialing is a contrast to the prevailing practices of interdisciplinary education.

Among the problems identified in interdisciplinary education, teritorial issues arise most often. Balassone (1981) is the author of an article relating to this topic. The published abstract - even more succinct,"there is no question that nurse practitioner students need to be prepared to define and defend their roles..but a practicum shared with students preparing for other health professions showed that they face very similar issues."(229) Mansfield and Seation (1981) providing a "response" to the dilemma of interdisciplinary continuing education include the report of a workshop held in 1976. Although presented virtually a decade ago, the identified barriers to interdisciplinary education are relevant today and include:

(1)Each health profession has a high degree of specialization.

(2)Each health profession is already pluralistic in form and structure.

(3)Each health profession engages in turf protection, at least to some degree.

(4)Adequate financing is not available,especially for research and administration of continuing education for health professionals.

(5)Adequate time is not available for health

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profesisonals to develop interdisciplinary modes on top of the responsibilities to their own professions and employers.

(6)Differences of opinion exist regarding the public-private perspectives and organizational alternatives for interdisciplinary cooperation.

(7)No leadership model currently exists for interdisciplinary cooperation. (175)

Perhaps even in response to the listed barriers, efforts have been directed toward interdisciplinary education. Bassoff (1983) reports an interdisciplinary education program at the University of Pennsylvania. Reviewing the literature Bassoff concludes

> "...there is little evidence that the movement (interdisciplinary education team or collaborative behavior) has had any substantial impact on the traditional education patterns of the health professions, who themselves are in an accelerating context of redefinition concerned mainly with their own territory and survival. The growing number of students and practitioners specializing in the physical and mental health field are as educationally isolated from one another as they have always been within large universities. Yet a substantial amount of their work time is spent in collaboration with others.(281)

In concluding the report of research relating to the attitudinal aspects of such an educational format (interdisciplinary),

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Bassoff declares, .1m 20

"The increasing interest in interprofessional education in health has generated many innovative approaches but little empirical data. We are all involved as partners and as facilitators. We are no longer members of one profession educating another but rather students learning together. The kinds of collaborative relationships we seek in health practice must begin as the stage of professional education." (285)

Also directing attention to the Health Care team role in health care delivery; Hale (1984) describes the circumstance "...health care deliverers are working with better informed clients and in close proximity with other health professionals. Unfortunately, clients often are more aware of the capabilities of different providers than providers themselves! This is due to a lack of interdisciplinary education for health care professionals."(16) She further claims that this circumstance has led to "confusion, misinformation, duplication of services, underutilization of skills, mistrust and even hostility among providers" and concludes this "is not a healthy atmosphere in which to build the type of health care team consumers are seeking". (16)

While the distinctive differences between a multidiscipline and interdiscipline approach to education are emphasized in this consideration, there is clear evidence that some of the needs of the interdiscipline approach could be met by the multidiscipline design in education.

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